ADDENDUM B - ALPHABETIC LISTING OF DATA ELEMENTS:

NOTE: ALL DATE FORMATS SHOULD BE (CCYYMMDD).

Data Element	Definition	Record	Field
Accommodations Days	A numeric count of accommodations days in accordance with payer instructions. Includes UB-92 revenue codes 10X through 21X.	50 Three additional iterations in related locations for RT 50, fields 11-13.	6
Accommodations Non-Covered Charges	Accommodations charges pertaining to the related UB-92 accommodations revenue code that are not covered by the primary payer as determined by the provider.	50 Three additional iterations in related locations for RT 50, fields 11-13.	8
Accommodations Noncovered Charges for the Batch	Sum of charges recorded in related field in RT 90, field 14.	95	9
Accommodations Noncovered Charges for the File	Sum of charges recorded in related field in RT 95, field 9.	99	7
Accommodations Rate	Per diem rate for related UB-92 accommodations revenue codes.	50 Three additional iterations in related locations for RT 50, fields 11-13.	5
Accommodations Revenue Code	UB-92 revenue center code for the accommodation provided. Includes codes 10X through 21X.	50 Three additional iterations in related locations for RT 50, fields 11-13.	4
Accommodations Total Charges	Total charges for the related revenue code.	50 Three additional iterations in related locations for RT 50, fields 11-13.	7
Accommodations Total Charges for the Batch	Sum of charges recorded in related field in RT 90, field 13.	95	8

Data Element	Definition	Record	Field
Accommodations Total Charges for the File	Sum of charges recorded in related field in RT 95, field 8.	99	6
Activities Permitted	Codes describing the activities permitted by the physician or for which physician's orders are present. "Other" is described in RT 73. 1 = Complete Bedrest 2 = Bedrest BRP 3 = Up as Tolerated 4 = Transfer Bed/Chair 5 = Exercises Prescribed 6 = Partial Weight Bearing 7 = Independent at Home 8 = Crutches 9 = Cane A = Wheelchair B = Walker C = No Restrictions D = Other A minimum of one must be present for the abbreviated POC.	71	16
Admission Date/Start of Care Date	The date the patient was admitted to the provider for inpatient care, outpatient service, or start of care. For an admission notice for hospice care, enter the effective date of election of hospice benefits. For RT 71, from most recent patient stay.	20 71 74 77-A	17 29 17 24
* Admission Hour	The hour during which the patient was admitted for inpatient care. Use hour in military time (00 to 23). If hour not known, use 99. Default to spaces if not applicable (e.g., outpatient).	20	18
Admitting Diagnosis/ Patient's Reason For Visit	The ICD-9-CM diagnosis code describing the patient's diagnosis or reason for visit at the time of admission or outpatient registration.	70	25
Air Ambulance Justification	Reason air ambulance was chosen instead of land transport. A01 = Life Threatening A02 = Instability of Roads A03 = Time Required for Land Transportation A04 = Local Ground Ambulance Lacks Staff or Equipment to Meet Patient Needs	75-02	6

* Not required for Medicare

	Data Element	Definition	Record	Field
		A05 = MD or RN Needed and Not Available to Accompany on Ground Transportation A06 = Patient Requires Maintenance of Critical Care Environment A07 = Other		
	Ancillary Charges (Ambulance)	Breakdown of charges for the ancillary charges listed below:	75-01	13-16
		Nonresuable Medical Surgical Supplies	75-01	13
		IV Solutions	75-01	14
		Oxygen/Oxygen Supplies	75-01	15
		Injectable Drugs	75-01	16
	Ancillary Charges Other (Ambulance)	Charges for ancillary services not listed in RT 75, sequence 01, fields 13-16.	75-02	7
	Ancillary Noncovered Charges for the Batch	Sum of charges recorded in related field, RT 90, field 16.	95	11
	Ancillary Noncovered Charges for the File	Sum of charges recorded in related field, RT 95, field 11.	99	9
	Ancillary Total Charges for the Batch	Sum of charges recorded in related field in RT 90, field 15.	95	10
	Ancillary Total Charges for the File	Sum of charges recorded in related field in RT 95, field 10.	99	8
*	Assignment of Benefits Certification Indicator	A code showing whether the provider has a signed form authorizing the third party payer to pay the provider. Y = Benefits assigned N = Benefits not assigned	30	17
	Attachment Submission Status	A code describing whether this is an original (A_) or updated (U_) submission of attachment records related to a specific claim. An updated submission indicates a re-submitted record series due to prior errors or additional information. A_ = Add U_ = Update	74	4

* Not required for Medicare

	Data Element	Definition	Record	Field
	Attending Physician Name	Name of the licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment	80 71	9 20-22
	Attending Physician Identifier	Number assigned to identify physician named in RT 80, field 8. For Medicare, only the NPI will be accepted beginning April 1, 1997.	80 77-A	5 6
	Attending Physician's Zip Code	The nine-digit ZIP code from the address field on the HCFA-485.	71	23
	Authorization	Any of 4 iterations of the authorization data contained in RT 34 used to provide detailed information regarding an authorization by a PRO or a payer. Any of the 4 iterations may be used to report information regarding an FDA investigational device exemption (IDE). Medicare requires IDE information.	34	4 - 12
*	Authorization From Date	Beginning date of a period being authorized for a stay extension, admission, or performance of a procedure.	34 Three additional iterations in related locations for RT 34, fields 10-12.	6
	Authorization HCPCS Number	A reference on RT 34 that indicates the HCPCS being authorized by the PRO or payer. For IDE, use the HCPCS code for the most similar conventional device. Required for Medicare IDE submission.	34 Three additional iterations in related locations for RT 34, fields 11-13.	9
	Authorization Number/ IDE Number	A number or other code issued to the provider by the payer or the PRO granting permission to the provider for a procedure, admission, or extension of stay. An IDE is an FDA assigned number for investigational device exemption. It is a seven position alphanumeric identifier.	34 Three additional iterations in related locations for RT 34, fields 10-12.	5

* Not required for Medicare

	Data Element	Definition	Record	Field
		Required for Medicare IDE submissions.		
*	Authorization Revenue Code	A reference on RT 34 that indicates the RC being authorized by the PRO or payer. Not required for Medicare IDE submission. See RT60.	34 Three additional iterations in related locations for RT34, 11-13.	8
*	Authorization Thru Date	Ending date of a period being authorized for a stay extension, admission, or performance of a procedure.	34 Three additional iterations in related locations for RT 34, fields 10-12.	7
	Authorization Type	A code that specifies the type of authorization contained in the particular iteration of the authorization for this payer. BB = Authorization number. Proves that permission was obtained to provide a service. LX = Qualified product list. Use to indicate RT 34 contains IDE information. Required for Medicare IDE submission.	34 Three additional iterations in related locations for RT 34, fields 10-12.	4
	Base Charge (Ambulance)	Base charge for ambulance service.	75-01	10
	Batch Number	Number assigned by the provider sequentially from 01 to nn to each batch of bills of a given type.	10	3
	Blood-Deductible Pints	The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible. Shown as value code 38.	41	16-39
	Blood-Furnished Pints	Total number of pints of whole blood or units of packed red cells furnished to the patient. Shown as value code 37.	41	16-39
	Blood-Replaced	The total number of pints of whole blood or units of packed red cells furnished to the patient that are replaced by or on behalf of the patient. Shown as value code 39.	41	16-39

* Not required for Medicare

	Data Element	Definition	Record	Field
	Certificate/ Social Security Number/Health Insurance Claim Identification Number	Insured's unique identification number assigned by the payer organization. For Medicare purposes, enter the patient's Medicare HIC number as on the Health Insurance Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the Social Security Office.	30	7
	Certification Period	From/To dates of period to be covered by this plan of treatment.	71	6-7
	Cert/Recert/ Mod	One of the following applicable codes: C = Certification R = Recertification M = Modified	71	28
	Certification Status	Indicates if submitted information for plan of treatment is a certification, recertification, or if certification is not required. 01 = Certification 02 = Recertification 99 = Not Applicable	77-R	17
*	CHAMPUS Insurer Provider Number	The number assigned to the provider by CHAMPUS. Provider number also appears on RT 30 in field 24. RT 30 may be repeated for each payer, A, B, and C.	10	8
	Coinsurance	That amount assumed by the hospital to be applied toward the patient's coinsurance amount involving the indicated payer. Shown as value code 09, 11, A2, B2, or C2.	41	16-39
	Coinsurance Days	The inpatient Medicare days occurring after the 60th day and before the 91st day in a single spell of illness.	30	22
	Condition Codes	Code(s) used to identify condition(s) relating to this bill that may affect payer processing.	41	4-13
	Contract Number	Number identifying a contracted organization participating in the Medicare Choices demonstration.	31	15

* Not required for Medicare

	Data Element	Definition	Record	Field
	Corresponding Data	Narrative data from the plan of treatment. See Addendum D for description of narrative.	73	6
	Cost Per Mile	Exact ambulance charge per mile.	75-01	12
*	Country Code	Four position code indicating the geographic location of the submitter or provider.	01 10	15 18
	Covered Days	The number of days covered by the primary payer, as qualified by the payer organization.	30	20
	Current Lab Value	See definition for "Non-Routine and Separately Billable Laboratory Tests"	76-L	4
	Data ID	Identifies submittal of HCFA-485 and HCFA-486 data or HCFA-486 data only 1 = HCFA-485 and HCFA-486 2 = HCFA-486 only Required for abbreviated POC.	71	4
	Data ID Number	Number corresponding to the data element narrative on plan of treatment. See Addendum D definitions of corresponding data for narrative definitions. 48510 = Medications 48514 = DME and Supplies 48515 = Safety Measures 48516 = Nutritional Requirements 48517 = Allergies 48521 = Orders for Discipline and Treatments 48522 = Goals/Rehabilitation 48616 = Potential/Discharge Plans and Updated Information 48617 = Functional Limitations/ Reason Homebound 48618 = Supplementary Plan of Treatment 48619 = Unusual Home/Social Environment 48620 = Times and Reasons Patient Not at Home 48621 = Medical/Nonmedical Reasons Patient Leaves Home	73	5
	Date of Current Lab	See definition for "Non-Routine and Separately Billable Laboratory Tests."	76-L	9

* Not required for Medicare

Data Element	Definition	Record	Field
Date of Current Test/Service	See definition for "Other Services."	76-M	20
Date of Extra Session	Report date of each extra dialysis session.	76-M	12
Date of Last Certification	Date last plan of treatment was certified, as applicable, to rehabilitation discipline.	77-R	18
Date (Agency) Last Contacted The Physician	Date of agency's most recent physician contact. Purpose stated in RT 73.	71	26
Date of Most Recent Event Requiring Cardiac Rehabilitation	Date of most recent medical event requiring cardiac rehabilitative services.	77-A	27
Date of Onset/ Exacerbation	The date of onset or exacerbation of the secondary diagnosis shown in RT 70 or RT 74. The related dates are entered in the same order as the secondary diagnosis codes.	71	11-14
Date of Onset/ Exacerbation of Principal Diagnosis	The date of onset or date of exacerbation of the diagnosis shown as principal in RT 70 or RT 74.	71 77-A	8 22
Date of Surgical Procedure	The date the surgery (field 9) was performed.	71	10
Date Physician Last Saw the Patient	Date (if known) that the patient was last seen by the physician.	71	25
Deductible	The amount assumed by the hospital to be applied to the patient's deductible. Amount involving the indicated payer (A, B, and/or C). Shown as value code 06, A1, B1, or C1.	41	16-39
Date Previous Lab	See definition for "Non-Routine and Separately Billable Laboratory Tests"	76-L	7
Date Previous Test/Service	See definition for "Other Services."	76-M	18

* Not required for Medicare

	Data Element	Definition	Record	Field
	Date of Receipt	The date the file was received from the submitter. This is to be entered by the receiver of the file.	01	19
	Date of Service	The line item date the service was performed.	61	13
	Destination Address	Address of the institution or home where patient transported by ambulance.	75-01	21-25
		Name	75-01	21
		Place	75-01	22
		City	75-01	23
		State	75-01	24
		Zip Code	75-01	25
	Discharge Date	Date that the patient was discharged from most recent inpatient care.	71	30
*	Discharge Hour	Hour that the patient was discharged from inpatient care. Use hour in military time (00 to 23). If hour not known, use 99. Default to spaces if not applicable (e.g., outpatient).	20	22
	Discipline	Code indicating discipline(s) ordered by physician: SN = Skilled Nursing PT = Physical Therapy ST = Speech language Pathology OT = Occupational Therapy MS = Medical Social Worker AI = Home Health Aide CR = Cardiac Rehabilitation RT = Respiratory (Inhalation) Therapy PS = Psychiatric Services For RT 77, AI (Home Health Aide) is not a valid code.	72 77	4 5
	Drugs Administered (Narrative)	Identifies medications administered as part of a psychiatric services plan of treatment.	77-R	23
	Drug Units	Number of standard units from the National Drug Code (NDC) administered to the patient. For example, if the standard dosage for the drug is 10 mg and 40 mg was administered, enter 0004 as the value in this field.	76-M Two additional iterations in related locations on RT 76, format type M, fields 10-11.	6

* Not required for Medicare

	Data Element	Definition	Record	Field
	Employer Location	The specific location for the employer of the individual identified in RT 30.	21 21 31	5-8 12-15 10-13
	Employer Name	Name of employer that may provide health care coverage for the individual identified in RT 30.	21 21 31	4 11 9
	Employer Qualifier	Identifies the patient's relationship to the person not claiming insurance. See "Patient Relationship to Insured" and its codes listed in §3604.	21	9a, 16a
	Employment Status Code	A code used to define the employment status of the individual identified by the name in RT 30. 1 = Employed full time 2 = Employed part time 3 = Not employed 4 = Self employed 5 = Retired 6 = On active military duty 7-8 = Reserved for national assignment 9 = Unknown	21 21 30	9 16 19
	Estimated Amount Due	The amount estimated by the hospital to be due from the indicated payer.	20 30	24 26
	Estimated Date of Completion of Outpatient Rehabilitation	An approximate date for discontinuance of outpatient rehabilitative services for a specific discipline due to goal achievement.	77-R	14
*	Estimated Responsibility	The amount estimated by the hospital to be paid by the indicated payer or patient. Shown as value code A3, B3, C3, or D3.	41	16-39
*	External Cause of Injury (E-code)	The ICD-9-CM code which describes the external cause of the injury, poisoning or adverse effect. Use of this data element is voluntary in States where E-coding is not required.	70	26
	Extra Dialysis Sessions	Reports the date and justification for extra dialysis sessions during the billing period.	76-M	12-14
		Date (for each session) Justification: Code specifies the reason for each extra session. 1 = New method of dialysis 2 = New caretaker 3 = Fluid overload 4 = Abnormal lab values	76-M 76-M Two additional iterations in related positions in RT 76, format type M, fields 15 and 16.	12 14

* Not required for Medicare

	Data Element	Definition	Record	Field
	Federal Tax Number (EIN)	The number assigned to the provider by the Federal government for tax reports purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).	10 95	4 2
*	Federal Tax Sub ID	Four position modifier to Federal Tax ID listed above.	10	5
	File Sequence and Serial Number	Sequence number from 01 to nn assigned to each file in this submission of records, followed by the inventory number of the file.	01	17
	Form Locator	The item number on the UB-92 hard copy form.	22	5-15
	Free Form Narrative	Text describing specific topics on the plan of treatment for outpatient rehabilitative services (e.g., initial assessment, progress report). Must have a narrative text indicator.	77-N	7
	Frequency and Duration	6 position code indicating the expected frequency and duration of an activity. For home health or outpatient rehabilitation, it is the expected frequency and duration of visits in the period covered by a plan of care/ treatment. It can also describe an expected number of activities, such as medication administration for ESRD patients. Position 1 is the number of visits/ activities. Positions 2-3 are an alpha expression of the period of time. Positions 4-6 are the duration of the plan. Enter the frequency codes in the order being rendered. Position 1 codes = 1-9 Position 2-3 codes = DA, WK, MO, Q_, __ DA = day, WK = week, MO = month, Q_ = every n days where n = the number in positions 4-6, __ = PRN (whenever necessary) Position 4-6 is duration in days. Codes = 001-999 unless positions 2-3 are blank, then enter PRN. A value of 999 indicates 2 ½ years or more. Examples: 1 visit daily for 10 days = 1DA010 1 visit every 2 months = 1Q_060 4 visits whenever necessary = 4__PRN	72 76-M 77-R	7 9 13

* Not required for Medicare

Data Element	Definition	Record	Field
	3 medication administrations/week for 3 months = 3WK090 1 medication administration every other week = 1Q_014 A minimum of one group must be present for the abbreviated POC.		
Functional Limitation Code	Codes describing the patient's functional limitations as assessed by the physician. "Other" is described in RT 73. 1 = Amputation 2 = Bowel/Bladder (Incontinence) 3 = Contracture 4 = Hearing 5 = Paralysis 6 = Endurance 7 = Ambulation 8 = Speech 9 = Legally Blind A = Dyspnea with Minimal Exertion B = Other A minimum of one must be present on abbreviated POC.	71	15
HCPCS/ Procedure Code	Procedure code reported in record types identify services so that appropriate payment can be made. HCPCS code is required for many specific types of outpatient services and a few inpatient services. May include up to two modifiers.	60 61 Two additional iterations in related locations for RT 60 and 61, fields 14-15.	5-7 5-7
HICN	Health Insurance Claim Identification Number.	74	5
HIPPS	Health Insurance Prospective Payment System	60 61	5-7 5-7
IDE	Investigational Device Exemption #	34	5
Injectable Drugs	Charges for all drugs administered intravenously, intramuscularly, or subcutaneously while providing ambulance services.	75-01	16
Inpatient Ancillary Noncovered Charges	Charges pertaining to the related UB-92 inpatient ancillary revenue center code that the primary payer will not cover.	60 Two additional iterations in related locations for RT 60, fields 13-14.	10

Data Element	Definition	Record	Field
Inpatient Ancillary Revenue Code	UB-92 revenue center code for the inpatient ancillary services provided. Include codes 22X through 99X.	60 Two additional iterations in related locations for RT 60, fields 13-14.	4
Inpatient Ancillary Total Charges	Total charges pertaining to the related UB-92 inpatient ancillary revenue center code.	60	9
Inpatient Ancillary Units of Service	A quantitative measure of services furnished, by inpatient UB-92 revenue center category, to or for the patient that includes items such as number of miles, pints of blood, number of renal dialysis treatments, etc.	60 Two additional iterations in related locations for RT 60, fields 13-14.	8
Insurance Group Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.	30	10
Insured Address	Insured's current mailing address. Address Line 1 Address Line 2 City State Zip	31 31 31 31 31 31	4-8 4 5 6 7 8
Insured Group Name	Name of the group or plan that provides insurance to the insured.	30	11
Insured's Name	Name of individual in whose name the insurance is carried. Last Name First Name Middle Initial	30 30 30 30	12-14 12 13 14
* Insured's Sex	Code indicating the sex of the insured. M = Male F = Female U = Unknown	30	15
Internal Control/ Document Control Number (ICN/DCN)	The control number assigned to the original bill by the payer or the payer's intermediary to identify a unique claim.	74	21

* Not required for Medicare

Data Element Definition Record Field

IV Solutions	Charges for supplies (e.g., needles, tubing, solutions) related to intravenous administration of solutions (e.g., saline), while providing ambulance services. Do not include charges for drugs administered intravenously. See "Injectable Drugs" on RT 75, sequence 01, field 16 for drug charges during ambulance services.	75-01	14
Justification for Extra Session	Specifies the reason for each extra dialysis session. 1 = New method of dialysis 2 = New caretaker 3 = Fluid overload 4 = Abnormal lab values	76-M	14
Lifetime Reserve Days	Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.	30	23
* Medicaid Provider Number	The number assigned to the provider by Medicaid. Provider number also appears on RT 30 in field 24. RT 30 may be repeated for each payer, A, B, and C.	10 30	7 24
Medical Record Number	Number assigned to patient by hospital or other provider to assist in retrieval of medical records.	20 74	25 6
Medical Surgical Supplies	Charges for non-reusable medical surgical supplies (e.g., bandages, topical solutions) used while providing ambulance services.	75-01	13
Medicare Covered	The following are applicable codes: Y= Covered N= Noncovered	71	24
Medicare Provider Number	The number assigned to the provider by Medicare. The provider number also appears in RT 30 in field 24. RT 30 may be repeated for each payer, A, B, and C.	10 30	6 24

* Not required for Medicare

Data Element	Definition	Record	Field

Medication Administration	Information related to the administration of medications used for end stage renal disease patients. See individual field definitions for information listed below for composite fields 10 and 11.	76-M Two additional iterations with related locations RT76, format M, fields 10 and 11.	5-9
	National Drug Code	76-M	5
	Drugs Units	76-M	6
	Place of Administration	76-M	7
	Route of Administration	76-M	8
	Frequency and Duration	76-M	9
Mental Status Code	Codes describing the patient's mental condition. "Other" is described in RT 73. 1 = Oriented 2 = Comatose 3 = Forgetful 4 = Depressed 5 = Disoriented 6 = Lethargic 7 = Agitated 8 = Other A minimum of one must be present for the abbreviated POC.	71	17
Modifier	Two position codes serving as modifier to HCPCS procedure.	60 61	6-7 6-7
Multiple Provider Billing File Indicator	A code indicating whether bills for more than one provider are contained on this file submission according to the following coding scheme. 1 = Single Provider 2 = Multiple Providers	01	3
Narrative Type Indicator	Used to identify the type of narrative text for outpatient rehabilitative services. 01 = Medical History/ Prior Functional Level 02 = Initial Assessment 03 = Functional Goals 04 = Plan of Treatment 05 = Progress Report 06 = Continued Treatment 07 = Justification for Admission 08 = Symptoms/Present Behavior	77-N	6

Data Element	Definition	Record	Field
National Drug Code	Used to identify the drug/medication administered. Use the National Drug	76-M Two additional	5

	Code list maintained by the Food and Drug Administration (FDA).	iterations in related positions on RT 76-M, fields 10 and 11.	
National Provider Identifier (NPI)	Refer to Medicare provider number.	10	6
Noncovered Accommodation Charges-Revenue Centers	Sum of accommodation charges not covered by primary payer for this bill as reflected in RT 50, field 8, and subsequent accommodation packets in RT type 50, fields 11-13.	90	14
Noncovered Ancillary Charges-Revenue Centers	Sum of "Ancillary Charges-Noncovered" for this bill as reflected in RT 60, field 10. If an outpatient batch, sum of "Noncovered Charges" for this bill as reflected in RT 61, fields 11, 14, or 15.	90	16
Noncovered Days	Days of care not covered by the primary payer.	30	21
Non-Routine and Separately Billable Laboratory Tests	Report the HCPCS code, results of previous test(s), date(s) of previous test(s), results of test(s) this billing period, and date(s) of test(s) this period for each separately billed test. Lab results are placed in the fields "lab value" which are seven position numeric fields with an implied decimal at five left of the decimal point. For example, the implied decimal is 99999.99	76-L Three additional iterations in related locations are in RT 76, format type L, fields 12-14.	5-9
	HCPCS Code	76-L	5
	Previous Lab Value	76-L	6
	Date Previous Lab	76-L	7
	Current Lab Value	76-L	8
	Date Current Lab	76-L	9
Number of Batches Billed this File	A count of the number of batches billed on this file or transmission.	99	5

Data Element	Definition	Record	Field
Number of 3M Batch	A count of the number of RT 71, 75-seq1, 76-seq1, and 77-A entries	95	7

Attachment Records	for this provider batch. (RT 10 to RT 95.)		
Number of Claims	A count of the number of RT 20 entries for this provider batch. (RT 10 to RT 95.)	95	6
Number of Claims for the File	A count of the number of RT 20 entries for this file (RT 01 through RT 99). Required only for benefit coordination (COB).	99	12
Number of Grace Days	The number of days determined by the the PRO to be necessary to arrange for the patient's post discharge care. Shown as value code 46.	41	16-39
Number of Miles (Ambulance)	Exact number of miles from point of pick-up to destination and return, if applicable.	75-01	11
Number of Trips (Ambulance)	Number of trips that pertain to this record. S1-9 = Single trips reported in RT 75, seq. 01, field 8 (code 1 - pick-up code) R1-9 = Round trips reported in RT 75, seq. 01, field 8 (code 2 - destination code)	75-01	7
Number of Records for the File	Total number of records from 01 through 99 in a file transmission. Required only for COB.	99	13
Occurrence Code	A code defining a significant event relating to this bill that may affect payer processing. Occurrence code and and occurrence date repeat for a total of 10 iterations.	40	8-26
Occurrence Date	Date associated with the occurrence span code in the preceding field. Both occurrence code and occurrence date repeat for a total of 10 iterations.	40	9-27
Occurrence Span Code	A code that identifies an event that relates to payment of the claim. The occurrence span code and both of the associated dates are repeated for a total of 2 iterations.	40	22 & 25

Data Element	Definition	Record	Field
Occurrence Span Dates	The from and through dates related to the occurrence pan code shown in the Preceding field.	40	23 & 26 24 & 27

Operating Physician Name	Name used by provider to identify the operating physician in provider records.	80	10
Operating Physician Identifier	Number used by provider to identify the operating physician in provider records.	80	6
Other Ancillary Charges (Ambulance)	Charge for ancillary services not listed in RT 75, sequence 01, fields 13-16.	75-01	7
Other Diagnosis Codes	The ICD-9-CM diagnoses codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.	70seq1 70seq2 74	5-11 4 13-16
* Other Insurer Provider Number	The number assigned to the provider by an insurer other than Medicare, Medicaid, or CHAMPUS.	10	9-10
Other Physician ID Name/Identifier	The name and/or number of the licensed physician other than the attending physician as defined by the payer organization.	80	7, 8 11, 12
Other Procedure Code	The code identifying the procedure, other than the principal procedure, performed during the billing period covered by this bill.	70seq1	15-23
Other Procedure Date	Date that the procedure indicated by the related code (preceding field) was performed.	70seq1	16-24

*Not required by Medicare

Data Element	Definition	Record	Field
Other Services	Report for each test/service for each separately billed item on and ESRD claim.	76-M Two additional iterations in related locations in RT 76,	17-20

		format M, fields 22-23.	
	HCPCS/CPT Code	76-M	17
	Date of Previous Test/Service (CCYYMMDD)	76-M	18
	Date of Current Test/Service (CCYYMMDD)	76-M	20
Outpatient Date of Service	The date the associated service as identified by the outpatient UB-92 revenue center code was delivered.	61 Two additional iterations in related locations for RT 61, fields 14-15.	9
Outpatient Noncovered Charges	Charges pertaining to the related outpatient UB-92 revenue center code that the primary payer will not cover.	61 Two additional iterations in related locations for RT 61, fields 14-15.	11
Outpatient Revenue Center Code	UB-92 revenue center code for outpatient ancillary services provided.	61 61	4 14-15
Outpatient Total Charges	Total charges for this bill (revenue code 0001).	61	10
Outpatient Units of Service	A quantitative measure of services furnished by outpatient UB-92 revenue center category to or for the patient that includes items such as number of miles, pints of blood, number of renal dialysis treatments, etc.	61	8
Oxygen/Oxygen Supplies	Charges for oxygen contents and supplies required during the administration of oxygen while providing ambulance services.	75-01	15
Patient Address	The address of the patient as qualified by the payer organization. Address Line 1 Address Line 2 City State (P.O. Code) Zip	20	12-16 12 13 14 15 16
Patient Birthdate	The date of birth of the patient. Includes 4 pos. year. (CCYYMMDD).	20 74	8 10

Data Element	Definition	Record	Field
Patient Control Number	Patient's unique alpha-numeric identification number assigned by the provider to facilitate retrieval of individual case records and posting of payment. Use to link multiple records	20-90-91	3

	for a single claim.		
* Patient Marital Status	The marital status of the patient at date of admission, outpatient service, or start of care. S = Single M = Married X = Legally Separated D = Divorced W = Widowed U = Unknown	20	9
Patient Name	Last name, first name, and middle initial of the patient.	20 74	4-6 7-9
	Last name	20 74	4 7
	First name	20 74	5 8
	Middle initial	20 74	6 9
Patient Receiving Care in 1861 (j)(1) Facility	Y = Yes N = No D = Do not know	71	27
Patient's Relationship to Insured	A code indicating the relationship of the patient to the identified insured. See §3604 for coding list.	30	18
Patient Sex	The sex of the patient as recorded at date of admission, outpatient service, or start of care. M = Male F = Female U = Unknown	20 74	7 11
Patient Status	A code indicating patient's status as of the statement covers thru date.	20	21

*Not required for Medicare

Data Element	Definition	Record	Field
Payer Address	Complete mailing address for the payer A organization from which the provider might expect some payment for the bill. Reiterates in sequences 02 and 03 for payers B and C.	32	5-9

	Address	32	5
	Address	32	6
	City	32	7
	State	32	8
	Zip Code	32	9
Payer Code	Identifies reason another payer is primary to Medicare. Z = Medicare is primary A = Working Aged None/Spouse with EGHP B = ESRD beneficiary in 30 month period with EGHP C = Any conditional payment situation D = Automobile no-fault or any liability insurance E = Workers Compensation F = PHS, other federal agency G = Disabled beneficiary under age 65 with LGHP H = Black Lung I = Veterans Administration (VA)	30	9
Payer Identification	Identifier designating the payer A organization from which the provider might expect some payment for the bill. Reiterates in sequences 02 and 03 for Payers B and C. This combines the formerly separate fields 5 (Payer Identification) and 6 (Payer Sub-identification). Non-Medicare payers may use the first five positions for the payer organization and the remaining four positions describe the specific office within the insurance carrier designated as responsible for this claim.	30	5-6
Payer Identification Indicator	Code indicating if the HCFA PAYER ID is being used in RT 30, fields 5-6. XV = HCFA Payer ID (2 spaces) = non-HCFA payer code.	30	8a
Payer Name	Name identifying each payer organization from which the provider might expect some payment for the bill.	30 32	8b 4
Payments Received	Amount patient has paid to the provider towards this bill.	20 30	23 25

Data Element	Definition	Record	Field
Physical Record Count (Excluding Screen)	The total number of physical records submitted for this bill, including all RTs 20 through 8n, and excluding RT 90.	90	4

Physician Number Qualifying Codes	The type of physician number being submitted. UP = UPIN FI = Federal Taxpayer ID Number SL = State License ID Number SP = Specialty License Number XX = National Provider Identifier (NPI)	80	4
Physician Referral Date (CCYYMMDD)	Date physician referred the patient for evaluation and treatment.	77-A	7
Physician Signature Date on Plan of Treatment (CCYYMMDD)	Indicates the date of written physician verification and/or certification of the plan of treatment for outpatient rehabilitative services.	77-A	9
Physician's Zip Code	The nine-digit ZIP code from the address field on Form HCFA-485.	71	23
Pick-up Address	Address where the ambulance pick-up was made, e.g., patient's home, hospital, scene of accident	75-01	17-20
	Place 75-01	17	
	City	75-01	18
	State 75-01	19	
	Zip Code	75-01	20
Pick-up Destination Code	Code describing pickup and destination points. For use where there is no applicable HCPCS modifier that can be reported on RT 61 or the modifier is less descriptive than the code below. Use one code for the originating trip (in field 8) and one for the return trip (in field 9). D01 = Nursing home to ESRD facility D02 = Hospital to ESRD facility D03 = ESRD facility to nursing home or hospital D04 = Transfer from hospital to air ambulance pickup site D05 = Transfer from air ambulance landing site to hospital	75-01	8-9

* Not required for Medicare

Data Element	Definition	Record	Field
	D06 = Transfer from accident site or acute event to air ambulance pick-up site		
Place of Administration	Indicates place of medication administration for ESRD patients. Used to determine if facility is authorized to administer medications in the setting. 1 = Dialysis unit 2 = Clinic 3 = Home	76-M	7
Plan of Treatment Status (Initial/Update)	Indicates whether the plan of treatment is the original or updated.	77-R	6
Plan of Treatment - Date Established (CCYYMMDD)	Date the plan of treatment was established by the rehabilitation professional.	77-R	7
Plan of Treatment - Period Covered (From - Through)	Period defining the inclusive dates covered by this plan of treatment.	77-R	9, 11
Previous Lab Value	See definition for "Non-routine and separately billable laboratory tests."	76-L	6
Principal Diagnosis Code	The ICD-9-CM diagnosis code describing the principal diagnosis (i.e., the medical condition chiefly responsible for the patient's condition and/or relating to fifty percent (50%) or more of a POC or POT.)	70 74	4 12
Principal Procedure Code	The code that identifies the principal procedure performed during the period covered by this bill.	70	13
Principal Procedure Date	The date on which the principal procedure described on the bill was performed.	70	14
Prior Hospitalization Dates (From-Through)	Indicate the inclusive dates of recent hospitalization (first to discharge day) pertinent to the patient's current plan of treatment for outpatient rehabilitative services.	77-A	18, 20

* Not required for Medicare

	Data Element	Definition	Record	Field
	Procedure Coding Method Used	An indicator that identifies the coding method used for procedure coding on the bill. 1-3 = Reserved for state and local assignment 4 = CPT-4 5 = HCPCS (HCFA Common Procedure Coding System) 6-8 = Reserved for National Assignment 9 = ICD-9-CM	70	27
	Processing Date ("Date Bill Submitted" on HCFA-1450)	Date submitter prepares file.	01	8
	Professional Designation of Rehabilitation Professional	Indicates the professional status and designation (e.g., LCSW, RN) of the rehabilitation professional establishing the plan of treatment for outpatient rehabilitation services.	77-A	15
	Prognosis	Code indicating physician's prognosis for the patient. 1 = Poor 2 = Guarded 3 = Fair 4 = Good 5 = Excellent	71 77-R	18 24
	Provider Address	Complete mailing address to which the provider wishes payment sent.	10	13-16
		Street address or box number	10	13
		City	10	14
		State (P.O. abbreviations)	10	15
		Zip	10	16
*	Provider FAX Number	FAX number for provider.	10	17
	Provider Identification Number	The Medicare provider number is the National Provider Identifier (NPI). The NPI is a ten position identifier issued by Medicare. An NPI is left justified in a field.	30	24
	Provider Name	Name of provider submitting this batch of bills.	10	12

* Not required for Medicare

Data Element	Definition	Record	Field
*Provider Telephone Number	Telephone number, including area code, at which the provider wishes to be contacted for claims development.	10	11
PRO Approval Indicator	An indicator describing the determination arrived at by the PRO. Shown as condition codes C1-C7.	41	4-13
PRO Approved Stay Dates	The first and last days that were approved when not all of the stay is approved by the PRO. Shown as occurrence span code M0.	40	28,31
Reason for Ambulance Transportation	Code indicating reason patient had to be transported by ambulance. R01 = Unconsciousness or shock R02 = Severe hemorrhage R03 = Seizure R04 = Spinal injury R05 = DOA R06 = Acute respiratory distress R07 = Restraining psychiatric patient R08 = Vehicle accident R09 = Cardiac incident R10 = Trauma other than vehicle R11 = Overdose/poisoning R12 = Bedbound R13 = Altered level of consciousness R14 = Burns R15 = Acute metabolic or endocrine disorders R16 = Acute surgical emergency non-trauma R17 = Hemodynamic instability R18 = Acute infectious process R19 = Neurological/neurovascular incident R20 = Organ procurement R21 = Accident, possible injury	75-01 Two additional iterations are located in RT 75 sequence 01, fields 5 and 6.	4
Reason for Bypass of Nearest Facility	Reason the nearest facility was bypassed for another one. B01 = Lack of appropriate facilities/ specialists B02 = Trauma center B03 = Burn center B04 = Other special care unit	75-02	5

*Not required for Medicare

Data Element	Definition	Record	Field
Reason for Transfer	Reason patient was transferred from one facility to another. T01 = Lack of appropriate facilities/ specialists T02 = Other	75-02	4
Receiver Identification	Number identifying to the provider the organization designated to receive this file.	01 95 99	6 3 3
*Receiver Sub-Identification	The identification of the specific location within the receiver organization designated to receive the tape or transmission.	01 95 99	7 4 4
Receiver Type Code	A code indicating the class of organization designated to receive this tape or transmission. A = Self Pay B = Workers Compensation C = Medicare D = Medicaid E = Other Federal Programs F = Insurance company G = Blue Cross H = CHAMPUS I = Other - local coding table applies Z = Multiple sources of payment	01	5
Record Format Type	Indicates specific record layout for a record type series with multiple formats under one record type designation. A = Administrative Data L = Laboratory Services M = Medication Data N = Narrative Text R = Treatment Data	76 77	4 4
Record Type nn Count	A count of RTs 20-2n through 80 fields 5 through 11 of this record. These fields must cross foot to the total in field 4 of this record.	90	5-11
Record Type 91 Qualifier	Indicates if RT 91 is present. Code "0" if not written or "1" if written.	90	12

*Not required for Medicare

Data Element	Definition	Record	Field
Rehabilitation Professional Identifier	Identifier assigned to the rehabilitation professional (e.g., therapist, nurse, psychologist) establishing the plan of treatment and/ or recommending continued need (or discontinuance) of care. Currently unavailable to all providers.	77-A	11
Rehabilitation Professional Name	Last name, first name, and middle initial of the rehabilitation professional (e.g., therapist, nurse, psychologist) establishing the plan of treatment and/or recommending continued need (or discontinuance) of care.		
	Last name	77-A	12
	First name	77-A	13
	Middle initial	77-A	14
Rehabilitation Professional Signature Date on Plan of Treatment (CCYYMMDD)	Date the rehabilitation professional verified and signed the plan of treatment for outpatient rehabilitative services.	77-A	16
Release of Information Certification Indicator	A code indicating that the provider has on file a signed statement permitting the payer to release data to other organizations in order to adjudicate the claim.	30	16
* Remarks	Notations relating specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements. Also used for overflow data for any element for which there is not enough space.	90 91	17 4
Revenue Code	Code that identifies a specific accommodation, ancillary service or billing calculation.	60 61	28, 111, 139 28, 111, 139

*Not required for Medicare

Data Element	Definition	Record	Field
Route of Administration	Used to report the method of medication administration. 1 = I.V. 2 = I.M. 3 = S.Q. 4 = Oral 5 = Topical 6-8= Reserved for national use 9 = Other	76-M	8
Route of Administration - IM	Identifies if any medications ordered are being administered intramuscularly.	77-R	20
Route of Administration - IV	Identifies if any medications ordered are being administered intravenously.	77-R	21
Route of Administration - PO	Identifies if any medications ordered are being administered by mouth.	77-R	22
Sequence Number	Sequential number from 01 to nn assigned to individual records within the same specific record type code to indicate the sequence of the physical record within the record type. Rts 21-2n do not have a sequence number greater than 01. Rts 01, 10, 90, 91, 95, and 99 do not have sequence numbers. The sequence number for RTs 30, 31, 34, and 80, are used as matching criteria to determine which type 30, type 31, type 34, and/or type 80 records are associated. Like sequence numbers indicate the records are associated. The sequence numbers for RT 77 indicate the sequence order of RT 77, not the format type (e.g., format A) of RT 77.	21-2n 30-3n 40-41 50-5n 60-6n 70-7n 80-8n	2 2 2 2 2 2 2

*Not required for Medicare

Data Element	Definition	Record	Field
Service Status (Continue/ Discontinue)	Indicates whether or not rehabilitative services should continue to achieve functional goals. Indicated at the end of the period covered in the plan of treatment.	77-R	16
SOC Date	Date covered home health services began. Required for abbreviated POC.	71	5
Source of Admission	A code indicating the source of this admission.	20	11
Source of Payment Code	A code indicating source of payment associated with this payer record. A = Self Pay B = Workers Compensation C = Medicare D = Medicaid E = Other Federal Programs F = Insurance company G = Blue Cross H = CHAMPUS I = Other - local coding table applies	30	4
Special Program Indicator	A code indicating that the services included on this bill are related to a special program. Shown as condition codes A0-A9.	41	4-13
State Code	Code that indicates the state coding structure to which the form locators apply.	22	4
Statement Covers Period	The beginning and ending service dates of the period covered by this bill.	20	19-20
Submitter Address	Mailing address of the submitter of this file. Address City State 12 Zip	01 11 13	10-13 10
Submitter EIN	Federally assigned Employer Identification Number (EIN) of file submitter. EIN is also referred to as the Tax Identification Number (TIN).	01 99	2 2

* Not required for Medicare

	Data Element	Definition	Record	Field
*	Submitter FAX Number	FAX number for the submitter.	01	14
	Submitter Name	Name of provider, third party billing service, or other organization to which the receiver/processor must direct inquiries regarding this transmittal.	01	9
	Submitter Telephone Number	Telephone number, including area code, at which the submitter wishes to be contacted for claim development.	01	16
	Surgical Procedure Code	The ICD-9-CM code describing the surgical procedure (if any) most relevant to the care being rendered.	71	9
	Test/Production Indicator	Indicates if claim being submitted is for adjudication or testing purposes. PROD = Production TEST = Test	01	18
	Total Accommodations Charges Revenue Centers	Total accommodation charges for this bill.	90	13
	Total Ancillary Charges-Revenue Centers	Total ancillary charges for this bill.	90	15
	Total Charges for the Batch	Sum of charges entered in RT 95, fields 8 (Accommodation Total Charges for the Batch) and 10 (Ancillary Charges for the Batch). Required only for COB.	95	12
	Total Charges for the File	Sum of charges entered in RT 99, fields 6 (Accommodation Total Charges for the File) and 8 (Ancillary Charges for the File). Required only for COB.	99	10
	Total Non-Covered Charges for the Batch	Sum of charges entered in RT 95, fields 9 (Accommodation Noncovered Charges for the Batch) and 11 (Ancillary Noncovered Charges for the Batch). Required only for COB.	95	13

* Not required for Medicare

Data Element	Definition	Record	Field
Total Non-Covered Charges for the File	Sum of charges entered in RT 99, fields 7 (Accommodation Noncovered Charges for the File) and 9 (Ancillary Noncovered Charges for the File). Required only for COB.	99	11
Total Visits Projected This Cert.	Total covered visits to be rendered by each discipline during the period covered by the plan of treatment. Include PRN visits. Required for abbreviated POC.	72	44
Total Visits From Start of Care (SOC)	The cumulative total visits (sessions) since the SOC through the last visit of of the current billing period.	77-A	26
Treatment Authorization Code	A number or other indicator that designates that the treatment covered by this bill is authorized by the PRO or by the payer. Three iterations, one each for payers A, B, and/or C.	40	5-7
Treatment Codes	Codes describing the treatment ordered by the physician. Show in ascending order. Valid codes are: A01-A30 = Skilled Nursing B01-B15 = Physical Therapy C01-C09 = Speech Therapy D01-D11 = Occupational Therapy E01-E06 = Medical School Services F01-F15 = Home Health Aide One or more codes must be present for each discipline (e.g., SN,PT, etc.). Required for abbreviated POC.	72	18-43
Treatment Diagnosis Code (ICD-9)	The ICD-9-CM code which describes the treatment diagnosis (e.g., 781.2 - abnormality of gait) for which 50% or more of the rehabilitative services are rendered for a specific discipline.	77-A	29
Treatment Diagnosis (Narrative)	Treatment diagnosis for which 50% or more of the rehabilitative services are rendered for a specific discipline.	77-A	30
Type of Admission	A code indicating the priority of this admission.	20	10
Type of Batch	A code indicating the types of bills that occur in this batch; i.e., between a provider record (RT 10), and a provider batch control (RT 95).	10 95	2 5

Data Element	Definition	Record	Field
Type of Bill	A code indicating the specific type of bill (hospital inpatient, SNF outpatient, adjustments, voids, etc.).	40	4
Type Of Facility	Coding indicating type of facility from which the patient was most recently discharged. A = Acute S = SNF I = ICF R = Rehabilitation Facility O = Other	71	31
Value Amount	Amount of money related to the associated value code.	41	17-39
Value Code	A code that identifies data of a monetary nature that is necessary for processing this claim as required by the payer organization.	41	16-38
Verbal Start of Care Date (CCYYMMDD)	The date the agency received the verbal orders from the physician, if this is prior to the date care started.	71	19
Version Code	A code that indicates the version of the National Specifications submitted on this file, disk, etc. 001 = UB-82 data set as finally approved 08/17/82. 003 = UB-82 data set as revised to handle $1,000,000 charges, bigger fields for units and UPINs. Effective 01/01/92 and 04/01/92. 004 = UB-92 data set as approved by NUBC 2/92. Effective 10/01/93. 041 = UB-92 data set as approved by the NUBC 2/96. Effective 10/01/96. 050 = UB-92 data set as approved by the NUBC 11/97. Effective 10/01/98. 060 = UB-92 data set as approved by the NUBC 11/99. Effective 4/01/00.	01	20
Visits (This Bill) Rel. to Prior Certification	Total visits on this bill rendered prior to recertification "to" date. If applicable, required for abbreviated POC.	72	5
Weight in Kg	Last recorded weight of the patient.	76-M	24